		FOR OHF USE			

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.   IDPH Facility ID Number: 0044073

Facility Name: Heritage Manor-Mount Zion

Address: 1225 WOODLAND DRIVE   Mt. Zion   62549
              Number   City   Zip Code

County: Macon

Telephone Number: (217) 864-2356   Fax # (   )

IDPA ID Number: 370909086024

Date of Initial License for Current Owners: 10/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code ____			Corporation		Other ____
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other ____		

In the event there are further questions about this report, please contact:
Name: _____   **Telephone Number:**   (   )

II.   CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from   01/01/2004   to   12/31/2004
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____   (Date)

(Type or Print Name)   Craig L. Ater

(Title)   Senior V.P. and Chief Financial Officer

Paid Preparer

(Signed) _____   (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone)   (309)823-7135   Fax # (   )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001   Phone # (217) 782-1630

Facility Name & ID Number   **Heritage Manor-Mount Zion**   **#**   **0044073**   **Report Period Beginning:**   **01/01/2004**   **Ending:**   **12/31/2004**

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2		3	4	
	Beds at Beginning of Report Period	**Licensure Level of Care**		**Beds at End of Report Period**	**Licensed Bed Days During Report Period**	
1	75	Skilled (SNF)		75	27,450	1
2		Skilled Pediatric (SNF/PED)				2
3		Intermediate (ICF)				3
4		Intermediate/DD				4
5		Sheltered Care (SC)				5
6		ICF/DD 16 or Less				6
7	75	TOTALS		75	27,450	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	**Patient Days by Level of Care and Primary Source of Payment**				
		Public Aid Recipient	**Private Pay**	**Other**	**Total**	
8	SNF	16,676	2,835	4,501	24,012	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	16,676	2,835	4,501	24,012	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)   87.48%

D. How many bed-hold days during this year were paid by Public Aid?   0   (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census?   yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐   NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐   NO ☒

I. On what date did you start providing long term care at this location?
Date started   10/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____   NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒   NO ☐   If YES, enter number of beds certified _____ and days of care provided   4,501

Medicare Intermediary   **Mutual of Omaha**

IV. ACCOUNTING BASIS

		MODIFIED	
ACCRUAL ☒		CASH* ☐	CASH* ☐

Is your fiscal year identical to your tax year?   YES ☒   NO ☐

Tax Year: _____   Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   Report Period Beginning: 01/01/2004   Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	109,456	10,514		119,970		119,970	2,801	122,771			1
2	Food Purchase		118,653		118,653		118,653		118,653			2
3	Housekeeping	49,603	11,897		61,500		61,500		61,500			3
4	Laundry	54,298	7,549		61,847		61,847		61,847			4
5	Heat and Other Utilities			76,601	76,601		76,601	857	77,458			5
6	Maintenance	34,700	29,355	16,309	80,364		80,364	10,045	90,409			6
7	Other (specify):*											7
8	**TOTAL General Services**	248,057	177,968	92,910	518,935		518,935	13,703	532,638			8
	B. Health Care and Programs											
9	Medical Director			18,187	18,187		18,187		18,187			9
10	Nursing and Medical Records	839,502	81,788	4,305	925,595		925,595		925,595			10
10a	Therapy		181,856	322,434	504,290	(414,955)	89,335	204,892	294,227			10a
11	Activities	25,942	2,548		28,490		28,490		28,490			11
12	Social Services	35,810		6,014	41,824		41,824		41,824			12
13	Nurse Aide Training							1,484	1,484			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	901,254	266,192	350,940	1,518,386	(414,955)	1,103,431	206,376	1,309,807			16
	C. General Administration											
17	Administrative	56,500			56,500		56,500	50,424	106,924			17
18	Directors Fees							4,077	4,077			18
19	Professional Services			203,098	203,098		203,098	(188,778)	14,320			19
20	Dues, Fees, Subscriptions & Promotions			73,387	73,387	(41,175)	32,212	(12,738)	19,474			20
21	Clerical & General Office Expenses	107,520	9,000	17,031	133,551		133,551	101,503	235,054			21
22	Employee Benefits & Payroll Taxes			287,002	287,002		287,002	26,147	313,149			22
23	Inservice Training & Education			1,523	1,523		1,523	415	1,938			23
24	Travel and Seminar			8,413	8,413		8,413	(6,414)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			44,306	44,306		44,306	1,531	45,837			26
27	Other (specify):*			12,076	12,076		12,076	(12,076)				27
28	**TOTAL General Administration**	164,020	9,000	646,836	819,856	(41,175)	778,681	(35,909)	742,772			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,313,331	453,160	1,090,686	2,857,177	(456,130)	2,401,047	184,170	2,585,217			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS   **Page 4**

Facility Name & ID Number   **Heritage Manor-Mount Zion**   **#0044073**   **Report Period Beginning:**   **01/01/2004**   **Ending:**   **12/31/2004**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			197,794	197,794		197,794	8,719	206,513			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,985	124,985		124,985	(47)	124,938			32
33	Real Estate Taxes			62,379	62,379		62,379		62,379			33
34	Rent-Facility & Grounds							4,964	4,964			34
35	Rent-Equipment & Vehicles			4,655	4,655		4,655	754	5,409			35
36	Other (specify):*											36
37	**TOTAL Ownership**			389,813	389,813		389,813	14,390	404,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					414,955	414,955		414,955			39
40	Barber and Beauty Shops		71	7,191	7,262		7,262		7,262			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,175	41,175		41,175			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		71	7,191	7,262	456,130	463,392		463,392			44
45	**GRAND TOTAL COST** (sum of lines 29, 37 & 44)	1,313,331	453,231	1,487,690	3,254,252		3,254,252	198,560	3,452,812			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

VI. ADJUSTMENT DETAIL   A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,200)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(47)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(572)	20		17
18	Fines and Penalties				18
19	Entertainment	(12,541)	24		19
20	Contributions	(76)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	4,021	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(14,922)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,337)		$	30

	OHF USE ONLY			
48	49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	235,897		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 235,897		36
37	**TOTAL ADJUSTMENTS (A) and (B))** (sum of SUBTOTALS	$ 198,560		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor-Mount Zion

	ID#	0044073
Report Period Beginning:	01/01/2004	
Ending:	12/31/2004	

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(1,200)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(572)	20	17
18				18
19			24	19
20		(76)	27	20
21				21
22		4,021	19	22
23				23
24		(12,000)	27	24
25		(14,922)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(24,749)		49

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	2,801	0	0	0	0	0	0	0	0	2,801	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	857	0	0	0	0	0	0	0	0	857	5
6	Maintenance	0	0	10,045	0	0	0	0	0	0	0	0	10,045	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	13,703	0	0	0	0	0	0	0	0	13,703	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	204,892	0	0	0	0	0	0	0	0	0	204,892	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,484	0	0	0	0	0	0	0	0	1,484	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	204,892	1,484	0	0	0	0	0	0	0	0	206,376	16
	C. General Administration													
17	Administrative	0	0	50,424	0	0	0	0	0	0	0	0	50,424	17
18	Directors Fees	0	0	4,077	0	0	0	0	0	0	0	0	4,077	18
19	Professional Services	4,021	(205,619)	12,820	0	0	0	0	0	0	0	0	(188,778)	19
20	Fees, Subscriptions & Promotions	(15,494)	0	2,756	0	0	0	0	0	0	0	0	(12,738)	20
21	Clerical & General Office Expenses	0	0	101,503	0	0	0	0	0	0	0	0	101,503	21
22	Employee Benefits & Payroll Taxes	0	0	26,147	0	0	0	0	0	0	0	0	26,147	22
23	Inservice Training & Education	0	0	415	0	0	0	0	0	0	0	0	415	23
24	Travel and Seminar	(12,541)	0	6,127	0	0	0	0	0	0	0	0	(6,414)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,531	0	0	0	0	0	0	0	0	1,531	26
27	Other (specify):*	(12,076)	0	0	0	0	0	0	0	0	0	0	(12,076)	27
28	TOTAL General Administration	(36,090)	(205,619)	205,800	0	0	0	0	0	0	0	0	(35,909)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,090)	(727)	220,987	0	0	0	0	0	0	0	0	184,170	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	8,719	0	0	0	0	0	0	0	8,719	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47)	0	0	0	0	0	0	0	0	0	0	(47)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	4,964	0	0	0	0	0	0	0	4,964	34
35	Rent-Equipment & Vehicles	(1,200)	0	0	1,954	0	0	0	0	0	0	0	754	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,247)	0	0	15,637	0	0	0	0	0	0	0	14,390	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(37,337)	(727)	220,987	15,637	0	0	0	0	0	0	0	198,560	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Therapy	100.00%			2
3	V								3
4	V	19	Adjustment for Related Organization	205,619	Heritage Enterprises, Inc.	100.00%		(205,619)	4
5	V								5
6	V	10a	Adjustment for Related Organization	181,006	GreenTree Pharmacy	100.00%	385,898	204,892	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 386,625			$ 385,898	$ * (727)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number   **Heritage Manor-Mount Zion**   **# 0044073**   **Report Period Beginning:** **01/01/2004** **Ending:** **12/31/2004**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.   ☐ YES   ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger		4	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
	Schedule V	Line	Item		Amount	Name of Related Organization				
15	V	1	Dietary	$		Heritage Enterprises, Inc.	100.00%	$ 2,801	$ 2,801	15
16	V	2	Food Purchase					0		16
17	V	3	Housekeeping					0		17
18	V	4	Laundry					0		18
19	V	5	Heat & Other Utilities					857	857	19
20	V	6	Maintenance					10,045	10,045	20
21	V	7	Other					0		21
22	V	9	Medical Director					0		22
23	V	10	Nursing & Medical Records					0		23
24	V	11	Activities					0		24
25	V	12	Social Service					0		25
26	V	13	Nurse Aide Training					1,484	1,484	26
27	V	14	Program Transportation					0		27
28	V	15	Other					0		28
29	V	17	Administrative					50,424	50,424	29
30	V	18	Directors Fees					4,077	4,077	30
31	V	19	Professional Services					12,820	12,820	31
32	V	20	Fees, Subscription, Promotions					2,756	2,756	32
33	V	21	Clerical & General Office Expenses					101,503	101,503	33
34	V	22	Employee Benefits & Payroll Taxes					26,147	26,147	34
35	V	23	Inservice Training & Education					415	415	35
36	V	24	Travel and Seminar					6,127	6,127	36
37	V	25	Other Admin. Staff Transportation					0		37
38	V	26	Insurance-Prop.Liab.Malpract					1,531	1,531	38
39	Total			$				$ 220,987	$ * 220,987	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   **Report Period Beginning:**   01/01/2004   **Ending:**   12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.   ☐ YES   ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger		4	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
	Schedule V	Line	Item		Amount	Name of Related Organization				
15	V	27	Other	$		Heritage Enterprises, Inc.		$ 0	$	15
16	V	30	Depreciation					8,719	8,719	16
17	V	31	Amortization of Pre-Op & Org					0		17
18	V	32	Interest					0		18
19	V	33	Real Estate Taxes					0		19
20	V	34	Rent-Facility & Grounds					4,964	4,964	20
21	V	35	Rent-Equipment & Vehicles					1,954	1,954	21
22	V	36	Other					0		22
23	V	38	Medically Nec Transportation					0		23
24	V	39	Ancillary Service Centers					0		24
25	V	40	Barber and Beauty Shops					0		25
26	V	41	Coffee and Gift Shops					0		26
27	V	42	Other					0		27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 15,637	$ * 15,637	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number | Heritage Manor-Mount Zion | # | 0044073 | Report Period Beginning: | 01/01/2004 | Ending: | 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home
must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Susie Jefferson	Director	Management	15.86		10		Salary/BOD	$ 2,494	Ln. 17/18	1
2	Tom Jefferson	Secretary	Management	16.21		10		Salary/BOD	10,707	Ln. 17/18	2
3	Craig Hart	Chairman	Management	31.95		10		Salary/BOD	13,558	Ln. 17/18	3
4	Cheryl Lowney	Executive Vice Presid	Management	0.49		40	100.00	Salary/BOD	7,375	Ln. 17/18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	9,838	Ln. 17/18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	4,890	Ln. 17/18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	5,639	Ln. 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 54,501		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s)
of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   **Report Period Beginning:**   01/01/2004   **Ending:**   2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office   **Name of Related Organization** _____

or parent organization costs? (See instructions.)   YES ☐   NO ☐   **Street Address** _____

    City / State / Zip Code _____

B. Show the allocation of costs below. If necessary, please attach worksheets.   **Phone Number** ( )

    Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,403	24	$ 89,729	$ 89,729	75	$ 2,801	1
2	2	Food Purchase	Beds	2,403	24	0	0	75	0	2
3	3	Housekeeping	Beds	2,403	24	0	0	75	0	3
4	4	Laundry	Beds	2,403	24	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,471	0	75	857	5
6	6	Maintenance	Beds	2,403	24	321,832	76,617	75	10,045	6
7	7	Other	Beds	2,403	24	0	0	75	0	7
8	9	Medical Director	Beds	2,403	24	0	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	0	75	0	9
10	11	Activities	Beds	2,403	24	0	0	75	0	10
11	12	Social Service	Beds	2,403	24	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,403	24	47,533	39,159	75	1,484	12
13	14	Program Transportation	Beds	2,403	24	0	0	75	0	13
14	15	Other	Beds	2,403	24	0	0	75	0	14
15	17	Administrative	Beds	2,403	24	1,615,588	1,615,588	75	50,424	15
16	18	Directors Fees	Beds	2,403	24	130,630	0	75	4,077	16
17	19	Professional Services	Beds	2,403	24	410,747	0	75	12,820	17
18	20	Fees, Subscription, Promotions	Beds	2,403	24	88,297	0	75	2,756	18
19	21	Clerical & General Office Expense	Beds	2,403	24	3,252,161	2,929,944	75	101,503	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,403	24	837,746	0	75	26,147	20
21	23	Inservice Training & Education	Beds	2,403	24	13,283	0	75	415	21
22	24	Travel and Seminar	Beds	2,403	24	196,325	0	75	6,127	22
23	25	Other Admin. Staff Transportatio	Beds	2,403	24	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	49,040	0	75	1,531	24
25	TOTALS					$ 7,080,382	$ 4,751,037		$ 220,987	25

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   **Report Period Beginning:**   01/01/2004   **Ending:**   2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office   **Name of Related Organization** _____
   or parent organization costs? (See instructions.)   YES [ ]   NO [ ]   **Street Address** _____
                                                                                                  City / State / Zip Code _____
                                                                                                  Phone Number ( )_____
B. Show the allocation of costs below. If necessary, please attach worksheets.   **Fax Number** ( )_____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,403	24	$	$	75	$	1
2	30	Depreciation	Beds	2,403	24	279,369		75	8,719	2
3	31	Amortization of Pre-Op & Org	Beds	2,403	24			75		3
4	32	Interest	Beds	2,403	24			75		4
5	33	Real Estate Taxes	Beds	2,403	24			75		5
6	34	Rent-Facility & Grounds	Beds	2,403	24	159,040		75	4,964	6
7	35	Rent-Equipment & Vehicles	Beds	2,403	24	62,608		75	1,954	7
8	36	Other	Beds	2,403	24			75		8
9	38	Medically Nec Transportation	Beds	2,403	24			75		9
10	39	Ancillary Service Centers	Beds	2,403	24			75		10
11	40	Barber and Beauty Shops	Beds	2,403	24			75		11
12	41	Coffee and Gift Shops	Beds	2,403	24			75		12
13	42	Other	Beds	2,403	24			75		13
14								75		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 501,017	$		$ 15,637	25

Facility Name & ID Number   Heritage Manor-Mount Zion   # 0044073   Report Period Beginning: 01/01/2004   Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related** YES	NO	3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note Original	7 Balance	8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	$	$ 1,991,696	01/15/06	variable	$ 112,348	1
2	LsSalle National Bank		xx	Mortgage							4,571	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							8,066	6
7	Central Office Allocation		xx	Working Capital								7
8												8
9	**TOTAL Facility Related**						$	$ 1,991,696			$ 124,985	9
	B. Non-Facility Related*											
10	Interest Income										(47)	10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$ (47)	14
15	**TOTALS (line 9+line14)**						$	$ 1,991,696			$ 124,938	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____   **Line #** _____

  * **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.**
    (See instructions.)

 ** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.**
    (See instructions.)

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   Report Period Beginning: 01/01/2004   Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important* **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 64,393	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 61,840	2
3. Under or (over) accrual (line 2 minus line 1).	$ (2,553)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 64,932	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $**_____ **For** _____ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 62,379	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	#
1999	52,736	8
2000	58,943	9
2001	60,891	10
2002	57,999	11
2003	64,304	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION $		16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME _____ Heritage Manor-Mount Zion _____   COUNTY   Macon _____

FACILITY IDPH LICENSE NUMBER _____0044073_____

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE   (   )_____   FAX #:   (   )_____

A.   **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-17-04-210-003		$ 61,840.00	$ 61,840.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,840.00	$ 61,840.00

B.   **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C.   **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Heritage Manor-Mount Zion   #   **0044073**   **Report Period Beginning:**   **01/01/2004 Ending:**   **12/31/2004**

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:**   **13,696**   **B. General Construction Type:**   **Exterior**   **brick/wood**   **Frame**   **wood**   **Number of Stories** _____

C. **Does the Operating Entity?**   [xx] **(a) Own the Facility**   [ ] **(b) Rent from a Related Organization.**   [ ] **(c) Rent from Completely Unrelated Organization.**

     (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. **Does the Operating Entity?**   [xx] **(a) Own the Equipment**   [ ] **(b) Rent equipment from a Related Organization.**   [ ] **(c) Rent equipment from Completely Unrelated Organization.**

     (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. **List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**
     none

F. **Does this cost report reflect any organization or pre-operating costs which are being amortized?**   [ ] **YES**   [xx] **NO**
     If so, please complete the following:

     1. Total Amount Incurred: _____   2. Number of Years Over Which it is Being Amortized: _____

     3. Current Period Amortization: _____   4. Dates Incurred: _____

         Nature of Costs: _____
         (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	Use	Square Feet	Year Acquired	Cost	
1	land			$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75				$ 1,076,000	$		$	$	$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Environmental Site Study		1998	1,662						9
10		Sign		1998	1,860						10
11		Air conditioning Unit		1999	5,732						11
12		Air Conditioner		1999	750						12
13		Professional Fees --Remodeling Project		1999	15,922						13
14											14
15		Facility Remodel -- Materials		2000	241,637						15
16		Professional Fees --Remodeling Project		2000	58,519						16
17		Kitchen A/C		2000	990						17
18		Fire Alarm		2000	1,997						18
19		Door Guard System		2000	3,444						19
20											20
21		Smoke Detectors		2001	3,775						21
22		Water Main Break		2001	3,426						22
23		Commercial Disposer		2001	757						23
24		Heat Pump		2001	5,158						24
25		Carpet Extract		2001	1,206						25
26				2001							26
27		Facility Remodel -- Contractor		2001	1,397,646						27
28		Professional Fees --Remodeling Project		2001	45,077						28
29											29
30		Facility Remodel -- Contractor		2002	2,762						30
31		Fire Dampers		2002	2,766						31
32											32
33											33
34		C/O Allocation						8,720	8,720		34
35		Book Depreciation				147,018		147,018		581,482	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   Report Period Beginning: 01/01/2004   Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Asphalt Sealing	2003	1,447						38
39	Sprinklers	2003	2,680						39
40	Storm Windows	2003	1,173						40
41									41
42	Water Heater	2004	1,114						42
43	Disposal	2004	871						43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,878,371	$ 147,018		$ 155,738	$ 8,720	$ 581,482	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   Report Period Beginning: 01/01/2004   Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 351,974	$ 50,776	$ 50,776	$		$ 261,303	71
72	Current Year Purchases	17,611						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 369,585	$ 50,776	$ 50,776	$		$ 261,303	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,297,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 197,794	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 206,514	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,720	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 842,785	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

*   **Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.**

**   This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease _____ .

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

	Fiscal Year Ending	Annual Rent
12.	_____/2005	$ _____
13.	_____/2006	$ _____
14.	_____/2007	$ _____

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,409 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number   Heritage Manor-Mount Zion   #   0044073   Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	☐ YES	2. CLASSROOM PORTION:
	☐ NO	IN-HOUSE PROGRAM ☐
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN OTHER FACILITY ☐
		COMMUNITY COLLEGE ☐
		HOURS PER AIDE ___

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS   (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number   **Heritage Manor-Mount Zion**   # **0044073**   Report Period Beginning: 01/01/2004   Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost)   (See instructions.)

	Service	Schedule V Line & Column Reference	Staff Units of Service	Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 134,262	$		$ 134,262	1
2	Licensed Speech and Language Development Therapist		hrs			40,947			40,947	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			133,166	845		134,011	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				400,896		400,896	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					14,059			14,059	13
14	TOTAL			$		$ 322,434	$ 401,741		$ 724,175	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on
     Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed
     on this schedule.

Facility Name & ID Number   **Heritage Manor-Mount Zion**   #   **0044073**   **Report Period Beginning:**   01/01/2004   **Ending:**   12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.   As of   12/31/2004   (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*				1 Operating	2 After Consolidation*	
	A. Current Assets					**C. Current Liabilities**			
1	Cash on Hand and in Banks	$ 13,424	$	1	26	Accounts Payable	$ 96,257	$	26
2	Cash-Patient Deposits	12,257		2	27	Officer's Accounts Payable			27
3	Accounts & Short-Term Notes Receivable-Patients (less allowance _____)	396,837		3	28	Accounts Payable-Patient Deposits	12,257		28
4	Supply Inventory (priced at _____)			4	29	Short-Term Notes Payable			29
5	Short-Term Investments			5	30	Accrued Salaries Payable	67,275		30
6	Prepaid Insurance	1,308		6	31	Accrued Taxes Payable (excluding real estate taxes)	20,782		31
7	Other Prepaid Expenses			7	32	Accrued Real Estate Taxes(Sch.IX-B)	64,932		32
8	Accounts Receivable (owners or related parties)	(1,167,764)		8	33	Accrued Interest Payable	11,304		33
9	Other(specify): _____			9	34	Deferred Compensation			34
	TOTAL Current Assets				35	Federal and State Income Taxes			35
10	**(sum of lines 1 thru 9)**	$ (743,938)	$	10		**Other Current Liabilities(specify):**			
	B. Long-Term Assets				36	_____			36
11	Long-Term Notes Receivable			11	37	_____			37
12	Long-Term Investments			12		**TOTAL Current Liabilities**			
13	Land	50,000		13	38	**(sum of lines 26 thru 37)**	$ 272,807	$	38
14	Buildings, at Historical Cost	2,878,372		14		**D. Long-Term Liabilities**			
15	Leasehold Improvements, at Historical Cost			15	39	Long-Term Notes Payable			39
16	Equipment, at Historical Cost	369,586		16	40	Mortgage Payable	2,603,400		40
17	Accumulated Depreciation (book methods)	(842,785)		17	41	Bonds Payable			41
18	Deferred Charges			18	42	Deferred Compensation			42
19	Organization & Pre-Operating Costs			19		**Other Long-Term Liabilities(specify):**			
20	Accumulated Amortization - Organization & Pre-Operating Costs			20	43	_____			43
					44	_____			44
21	Restricted Funds			21		**TOTAL Long-Term Liabilities**			
22	Other Long-Term Assets (specify): _____			22	45	**(sum of lines 39 thru 44)**	$ 2,603,400	$	45
23	Other(specify): _____	4,952		23		**TOTAL LIABILITIES**			
	TOTAL Long-Term Assets				46	**(sum of lines 38 and 45)**	$ 2,876,207	$	46
24	**(sum of lines 11 thru 23)**	$ 2,460,125	$	24	47	**TOTAL EQUITY(page 18, line 24)**	$ (1,160,020)	$	47
	TOTAL ASSETS					**TOTAL LIABILITIES AND EQUITY**			
25	**(sum of lines 10 and 24)**	$ 1,716,187	$	25	48	**(sum of lines 46 and 47)**	$ 1,716,187	$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,212,994)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,212,994)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	52,974	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 52,974	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,160,020)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount (1)			Expenses	Amount (2)	
	A. Inpatient Care				**A. Operating Expenses**		
1	Gross Revenue -- All Levels of Care	$ 3,325,857	1	31	General Services	518,935	31
2	Discounts and Allowances for all Levels	(1,146,513)	2	32	Health Care	1,518,386	32
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,179,344	3	33	General Administration	819,856	33
	B. Ancillary Revenue				**B. Capital Expense**		
4	Day Care		4	34	Ownership	389,813	34
5	Other Care for Outpatients		5		**C. Ancillary Expense**		
6	Therapy	800,493	6	35	Special Cost Centers	7,262	35
7	Oxygen		7	36	Provider Participation Fee		36
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 800,493	8		**D. Other Expenses (specify):**		
	C. Other Operating Revenue			37			37
9	Payments for Education		9	38			38
10	Other Government Grants		10	39			39
11	Nurses Aide Training Reimbursements		11				
12	Gift and Coffee Shop	1,446	12	40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,254,252	40
13	Barber and Beauty Care	7,077	13				
14	Non-Patient Meals		14	41	**Income before Income Taxes (line 30 minus line 40)****	52,974	41
15	Telephone, Television and Radio		15				
16	Rental of Facility Space		16	42	**Income Taxes**		42
17	Sale of Drugs	318,779	17				
18	Sale of Supplies to Non-Patients		18	43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 52,974	43
19	Laboratory		19				
20	Radiology and X-Ray		20				
21	Other Medical Services	40	21				
22	Laundry		22				
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 327,342	23				
	D. Non-Operating Revenue						
24	Contributions		24				
25	Interest and Other Investment Income***	47	25				
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 47	26				
	E. Other Revenue (specify):****						
27	**Settlement Income (Insurance, Legal, Etc.)**		27				
28			28				
28a			28a				
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29				
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,307,226	30				

*   This must agree with page 4, line 45, column 4.

**   Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

***   See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number   Heritage Manor-Mount Zion   **# 0044073**   **Report Period Beginning:**   01/01/2004   **Ending:**   12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	936	944	$ 19,344	$ 20.49	1
2	Assistant Director of Nursing	1,008	1,064	24,576	23.10	2
3	Registered Nurses	1,987	1,987	43,465	21.87	3
4	Licensed Practical Nurses	13,393	14,039	244,077	17.39	4
5	Nurse Aides & Orderlies	44,684	47,792	486,914	10.19	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,227	1,481	21,126	14.26	8
9	Activity Director					9
10	Activity Assistants	2,690	2,846	25,942	9.12	10
11	Social Service Workers	2,111	2,168	35,810	16.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,769	6,679	109,456	16.39	15
16	Dishwashers					16
17	Maintenance Workers	2,617	2,725	34,700	12.73	17
18	Housekeepers	6,054	6,247	49,603	7.94	18
19	Laundry	6,020	6,281	54,298	8.64	19
20	Administrator	1,900	2,080	56,500	27.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,323	8,044	107,520	13.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,719	104,377	$ 1,313,331 *	$ 12.58	34

* This total must agree with page 4, column 1, line 45.   ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		18,187		36
37	Medical Records Consultant		1,400		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,040		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		6,014		45
46	Other(specify) _____				46
47					47
48	_____				48
49	TOTAL (lines 35 - 48)		$ 27,641		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number   **Heritage Manor-Mount Zion**   # **0044073**   Report Period Beginning: **01/01/2004**   Ending: **12/31/2004**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marge Oblinger			$ 56,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,500

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritge Enterprises	Mgt Fees	$ 205,619
Robert McQuellen	Consulting	1,500
		0
		0
Recoupment of prior fees		(4,021)
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 203,098

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,018
Unemployment Compensation Insurance	22,285
FICA Taxes	100,470
Employee Health Insurance	80,780
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	9,449
Employee Benefits - central office	26,147
TOTAL (agree to Schedule V, line 22, col.8)	$ 313,149

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	10,324
Health Care Worker Background Check	
(Indicate # of checks performed ____)	900
Central Office Allocation	2,756
Promotional Advertising	5,963
Public Relations	8,959
Dues and Subscriptions	4,790
License and Fees	1,276
Less: Public Relations Expense	(8,959)
Non-allowable advertising	(572)
Yellow page advertising	(5,963)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,474

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,106
	64
Seminar Expense	4,243
	(12,541)
	6,127
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications   **See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?   **no**

(2) Are there any dues to nursing home associations included on the cost report?   **yes**
If YES, give association name and amount.   **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political
action organization?   **yes**   If YES, have these costs
been properly adjusted out of the cost report?   **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year?   **no**   If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?   **yes**
What was the average life used for new equipment added during this period?   **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,000**   Line   **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?   **yes**   If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?   **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?   YES   **xx**   NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)?   YES _____   NO   **xx**   If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **41,175**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee?   **no**   If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V?   **yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **yes**   For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0**   Has any meal income been offset against
related costs?   **yes**   Indicate the amount. $ **136**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?   **no**
   If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
   residents?   **no**   If YES, please indicate the amount of income earned from such a
   program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?   **100%**
d. Have vehicle usage logs been maintained?   **yes**
e. Are all vehicles stored at the nursing home during the night and all other
   times when not in use?   **yes**
f. Has the cost for commuting or other personal use of autos been adjusted
   out of the cost report?   **yes**
g. Does the facility transport residents to and from day training?   no
   Indicate the amount of income earned from providing such
   transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?   **yes**
Firm Name: **Sulaski & Webb**   The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached?   **no**   If no, please explain.   **Not available at this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V?   **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report?   **yes**
Attach invoices and a summary of services for all architect and appraisal fees.